INSTRUCTIONS FOR COMPLETING FORM 13A-Web:
MEDICAL TRANSPORTATION REIMBURSEMENT FORM

PAYEE INFORMATION:

Payee Name: Print the first and last name, full mailing address and telephone number of the person who will receive the payment.
Key Name: Print the Key Name received upon enrollment. If you do not have a key name or have not been enrolled, contact the Medicaid Transportation Coordinator at 1-800-852-3345, ext. 3770 (in-state only) or (603) 271-3770.
Resource #: Print the assigned Resource Number received upon enrollment. If you do not have a Resource Number or have not been enrolled, contact the Medicaid Transportation Coordinator at 1-800-852-3345, ext. 3770 (in-state only) or (603) 271-3770.
Relationship to Recipient: Check the box that applies to your relationship to the recipient.
Service Code: Circle the appropriate Service Code which describes your type of transportation enrollment.

RECIPIENT INFORMATION:

First Name: Print up to the first three letters of the first name of the Medicaid or Healthy Kids-Gold recipient.
Last Name: Print up to the first three letters of the last name of the Medicaid or Healthy Kids-Gold recipient.
Medicaid ID #: Print the Medicaid or Healthy Kids-Gold recipient's individual number from his/her Medicaid or Healthy Kids-Gold ID card.

TRIP INFORMATION:

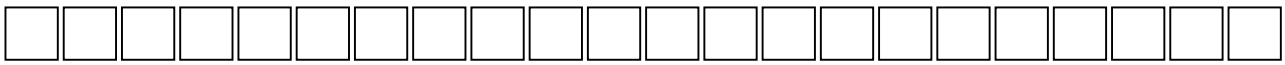
If payee is **Self or Parent/Household Member**	**OR:**	If payee is **Volunteer**
From: Print up to the first 8 letters of the Recipient's home town or city, and the zip code.		From: Print up to the first 8 letters of the Volunteer's home town or city, and the zip code.
To: Print up to the first 8 letters of the Medical Provider's town or city and state.		To: Print up to the first 8 letters of the Recipient's home town or city.
		To: Print up to the first 8 letters of the Medical Provider's town or city and state.

One Way/Round Trip: Check if the trip was made only one way, or if it was round trip (round trip means to the medical provider and return to the recipient's home).

Total Miles per Trip: Enter the number of miles traveled on the trip date. For volunteers, total miles should be from your residence and return if it was round trip. (Leave blank if provider type code is B).

Tolls/Parking: If tolls and parking for this trip total $3.00 or more, enter the total amount. Receipts, with trip date printed on them, must be attached and must show the same trip date as stated on the claim form.

Medical Provider Name: Print the name of the medical service provider, in last name, first name order. Example:



Medical Provider Type Code: Enter the provider type code from the list in the shaded area below the code (1, 2, 3, etc.) If type code is B, leave total miles per trip blank and attach bus receipts.

Trip Date: Enter the month, day and year the medical service was provided. This should be the date the transportation was provided.

Medical Provider/Pharmacy Signature: The Medicaid or Healthy Kids-Gold recipient, or their authorized representative, is responsible for obtaining the medical provider's signature on this claim form at the time of service. **The medical provider must sign and date this form on the same day as the date of service being billed. If the provider is using a signature stamp, both the yellow and white copies must be stamped.**

Recipient Signature and Date: The Medicaid or Healthy Kids-Gold recipient must sign and date the form. If the recipient is a minor, the parent or legal guardian must sign on his/her behalf.

Payee Signature and Date: The payee signs and dates the form after s/he has made sure the form is complete.

PROCESSING INFORMATION:

Claims must be received by the Bureau of Data Management **within 90 days of the date of service** on the claim. No reimbursement will be made for claims received after 90 days from the trip date.

For payment, send claims to:

NH Department of Health & Human Services, Bureau of Data Management, PO Box 2000, Concord, NH 03302-2000

Keep a copy for your records so that you may compare the claim for services provided with the payments received. Please allow 4 to 5 weeks for payment of a claim. Claims that contain errors may need to be returned to you for correction.

State of New Hampshire
Department of Health and Human Services

13A-Web
1/06

MFS Use Only
F-_____ **Auth:**_____
F-_____ **Auth:**_____
F-_____ **Auth:**_____

MEDICAL TRANSPORTATION REIMBURSEMENT FORM

PAYEE /RESOURCE INFORMATION

Key Name: ☐☐☐☐☐ **Resource #:** ☐☐☐☐☐☐☐☐☐☐☐☐

Payee Name and Address:

_____
First Last

_____
Mailing Address

_____ _____ _____
City/Town State Zip Code

Relationship to Recipient:
☐ 1. Self
☐ 2. Parent/Household Member
☐ 3. Volunteer

Service Codes: (Circle one of the following)
RT= Recipient Transporter
VT=Volunteer Transporter
TT= Taxi Transporter

( ) _____
Telephone #

RECIPIENT INFORMATION

☐☐☐ Recipient First Name
☐☐☐ Recipient Last Name
☐☐☐☐☐☐☐☐☐☐☐☐ Recipient Medicaid or Healthy Kids-Gold ID Number

TRIP INFORMATION

If Payee is Self, Parent or Household Member: (RT= Recipient Transporter) **OR** If Payee is Volunteer: (VT=Volunteer Transporter TT = Taxi Transporter)

From:
☐☐☐☐☐☐☐☐ ☐☐☐☐☐ (Recipient's Home Town/City) (Zip Code)

To:
☐☐☐☐☐☐☐☐ ☐☐ (Medical Provider's Town/City) (State)

From:
☐☐☐☐☐☐☐☐ ☐☐☐☐☐ (Volunteer's Home Town/City) (Zip Code)

To:
☐☐☐☐☐☐☐☐ (Recipient's Home Town/City)

To:
☐☐☐☐☐☐☐☐ ☐☐ (Medical Provider's Town/City) (State)

☐ 1. One Way Trip
☐ 2. Round Trip

☐☐☐ Total Miles Per Trip

$☐☐.☐☐ Tolls/Parking (Minimum $3.00, Receipts Required)

☐ Receipts Verified **BDM Use Only**

☐☐☐☐☐☐ **OMBP Use Only**

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Medical Provider Name

Medical Provider Type Code: ☐

Medical Provider Type Codes:
[1] Hospital
[2] Physician/Mental Health Provider
[3] Dentist
[4] Therapies (Physical/Speech/Occupational)
[5] Dialysis
[6] Referral/Specialist
[7] Pharmacy
[A] OMBP Use Only
[B] Bus Transportation with receipts

Trip Date (MM/DD/YY)
☐☐/☐☐/☐☐

Medical Provider/Pharmacy Signature (Rubber stamp preferred on both copies)
I certify that medical services were rendered for this recipient on the trip date indicated.

_____ Date_____

If Pharmacy, do you provide free delivery to recipient's residence? ☐Yes ☐No

This is to certify that the information above is true, accurate, and complete. I understand that payment of this claim may be from Federal and State funds and that any false claims, statements, documents or the concealment of material fact may be prosecuted under applicable Federal and State Laws.

Recipient Signature:_____ Date:_____

Payee Signature:_____ Date:_____

For payment, submit the completed Form 13A-Web to: NH Department of Health and Human Services, Bureau of Data Management, PO Box 2000, Concord NH 03302-2000

SR 06-XX

Keep a photocopy of the completed Form 13A-Web for your records.

(3YC)